(Edition Type)

INDIVIDUAL SUPPORT PLAN

(Person's Full Name)

ISP Effective Date:

Date ISP Amended:

FACE SHEET

Person's Information:

Home Address: _____

City, State, Zip: _____

Date of Birth: _____ Phone: _____

Social Security Number: _____

Waiver enrollment date: _____ Regional Office: W M E

Conservator or Other Legal Representative:

Name: _____

Relationship: _____ Phone: _____

Street Address: _____

City, State, Zip: _____

Other Primary Contact:

Name: _____

Relationship: _____ Phone: _____

Street Address: _____

City, State, Zip: _____

[ ] YES [ ] NO Is the Primary Contact eligible to receive Protected Health Information in accordance with HIPAA requirements?

[ ] YES [ ] NO Is there a signed release of information form?

Planning Meeting Details:

Location: _____

For an amendment, check each section that will replace the previous edition of that section in the ISP.

[ ] A. Personal Focus
[ ] B. Action Plan
[ ] C. Services and Supports
[ ] D. Behavior Support Plan
[ ] E. Planning Meeting Signature Sheet

This Edition of ISP Prepared By:

Name: _____

Position: _____

Agency: _____

Phone: _____ Date: _____

Reason for Submission to DMRS: (Select one reason below.)

(Select One)

Imprint Date of Receipt of the ISP or Amendment by the DMRS Regional Office in the Space Below:

_____

(Edition Type)

INDIVIDUAL SUPPORT PLAN

(Person's Full Name)

ISP Effective Date:

[ ] Amended Section A

Date ISP Amended:

A. PERSONAL FOCUS

Purpose: This section is written to ensure that the ISP is focused on the person. The information reflects what this person, his/her family and/or legal representative, and the persons they have chosen, have told the preparer of this ISP. Important information from the person's records also is included as desired by the person, family or his/her legal representative. The Personal Focus is completed prior to, and distributed to everyone invited to the planning meeting. This information provides the foundation around which supports, services, outcomes, goals, actions, etc. are planned and carried out for this person. If in this Personal Focus, the person or his/his legal representative and/or family indicate that anything needs to be different, changed, or ensured in the person's life, it will be addressed in the Action Plan of this ISP.

1. Description of the Person's Current Life:

Describe the Person's Current Situation and What is Important to the Person.	**Specify What the Person is Dissatisfied with and What Needs to be Changed.** (Any changes should be addressed in the Action Plan of this ISP.)
a. Home: (Click & Type Here)	(Click & Type Here)
b. Day Activities: Include school, day, job, and volunteer activities. (Click & Type Here)	(Click & Type Here)
c. Relationships and Community Membership: (Click & Type Here)	(Click & Type Here)
d. Chronic Medical Conditions: List chronic medical, psychiatric, and other health conditions. (Click & Type Here)	(Click & Type Here)

(Edition Type)

INDIVIDUAL SUPPORT PLAN

(Person's Full Name)

ISP Effective Date:

Date ISP Amended:

A. PERSONAL FOCUS

e. Allergies: List food, drug, and other allergies. (Click & Type Here)	(Click & Type Here)
f. Mealtime Issues List food likes and dislikes, special diets, dining issues, weight issues, etc. (Click & Type Here)	(Click & Type Here)

2. What Else is Important to This Person? Specify the person's preferences, choices, and non-negotiables.

(Click & Type Here)

3. Personal Funds Management: Specify the person's preferences regarding personal funds management.

(Click & Type Here)

4. Decision-Making: Specify the person's rights and responsibilities for making other decisions.

(Click & Type Here)

5. Communication: Specify how the person communicates with others and the best way to communicate with the person.

(Click & Type Here)

6. Other Important Things that Supporters Should Know:

(Click & Type Here)

(Edition Type)

INDIVIDUAL SUPPORT PLAN

ISP Effective Date:

(Person's Full Name)

[ ] Amended Section B

Date ISP Amended:

B. ACTION PLAN

Purpose: This Action Plan is developed based on information gathered from the person and the person's family or legal representative during a meeting with the person's support planning team and from assessments and other information sources.

The Action Plan consists of six parts:

1. Identifying actions for achieving the person's desired outcomes;
2. Identifying actions for meeting the person's needs and preferences;
3. Identify actions to address any other risks in the person's life;
4. Planning actions to support the person's activities of daily life;
5. Planning actions for supporting the person during non-routine events; and,
6. Recording the action to be taken as the result of any other issues discussed during the planning meeting. The member of the team chosen and designated as the provider of the service or support used or needed by the person will be responsible for carrying out and documenting the implementation and/or completion of that particular action.

1. PERSONAL OUTCOMES:

Outcome & Personal Choice: Specify the person's desired personal outcomes and indicate barriers or risks.	**Action Needed**: Specify the actions needed to address, manage, or alleviate the risk and the type, frequency (hours/day, days/week), and location of supports and services needed.	**Responsible Person or Entity**	**Projected Timeframes**

2. SUPPORTS FOR DAILY LIFE: These are services and supports needed or preferred to ensure the person's health, safety, and welfare, and individual growth and development. These may involve home, work, school, play, church, community, etc.

Activity: List activity, barriers and risks, and, if applicable, the therapeutic goal and measurable outcome.	**Action Needed**: Specify the type, frequency (hours/day, days/week), and location of supports and services needed, including special equipment, technology, treatment, etc.	**Responsible Person or Entity**	**Projected Timeframes**

(Edition Type)

INDIVIDUAL SUPPORT PLAN

(Person's Full Name)

ISP Effective Date:

Date ISP Amended:

B. ACTION PLAN

3. OTHER RISKS IN THIS PERSON'S LIFE: If not addressed elsewhere in this Action Plan.			
Risk & Personal Choice: List risks identified from risk assessments or other assessments and the person's choice regarding the risk. If the person does not have 24 hour supervision, the type of supervision needed must be specified.	**Action Needed**: Specify the actions needed to address, manage, or alleviate the risk and the type, frequency (hours/day, days/week), and location of supports and services needed.	**Responsible Person or Entity**	**Projected Timeframes**

4. SUPPORTS FOR NON-ROUTINE EVENTS: These are events that would vary from the regular routine and that reasonably could be anticipated and planned for in advance so that supports could be arranged. Significant events may require the ISP to be amended.			
Event: Examples include vacation, travel, visiting family, job loss, school closure, hospitalization, illness, crisis, respite, etc.	**Action Needed**: Specify the type, frequency (hours/day, days/week), and location of supports and services needed, including special equipment, technology, treatment, etc.	**Responsible Person or Entity**	**Projected Timeframes**

5. PLANNING MEETING FOLLOW-UP ISSUES: Include any issue that needs follow-up or that could not be addressed during the meeting.			
Discussion Item: List other items discussed during the meeting that need to be recorded for consideration or follow-up.	**Action Needed**: Specify actions that are needed, if any.	**Responsible Person or Entity**	**Projected Timeframes**

(Edition Type)

INDIVIDUAL SUPPORT PLAN

(Person's Full Name)

ISP Effective Date:

[ ] Amended Section C1

Date ISP Amended:

C. SERVICES AND SUPPORTS

Purpose: The purpose of Section C1 is to identify the supports and services that are being used, or are required, to meet the needs of the person.

1. **Medicaid State Plan and Other Supports and Services (excluding DMRS or HCBS waiver services):** The following supports and services include services provided under the Medicaid State Plan/TennCare Program; services available through other local, state, or federally mandated programs or eligibility-based programs; and other generic community supports used by the person. Excluded are DMRS or Medicaid HCBS waiver services which are listed in Section C2.

Service or Support	Provider, Agency, or Program
[ ] TennCare Program/Medicaid State Plan Services	**Name of MCO:** **Name of BHO:**
[ ] Medicare Coverage	**Administering Agency:**
[ ] Dental Insurance / Coverage	**Name of Carrier / Plan:** **Name of Dentist:**
[ ] Local Educational Services	**Name of School District:**
[ ] Vocational Rehabilitation Services	**DRS Provider:**
[ ] Food Stamp Program	**Issuing Agency:** Tennessee Department of Human Services
[ ] Federal / State Housing Assistance	**Name of Program:**
[ ] Advocacy Services	**Name of Program:**
[ ] Special Transportation Services	**Public Transportation Authority / Locality:**
[ ] Paid Conservatorship Services	**Corporate Entity Name:**
[ ] Senior / Aging Support Services	**Name of Program / Service:**
[ ] Specify:	
[ ] Specify:	

(Edition Type)

INDIVIDUAL SUPPORT PLAN

(Person's Full Name)

ISP Effective Date:

Date ISP Amended:

[ ] Amended Section C2

C. SERVICES AND SUPPORTS

2. DMRS or Medicaid HCBS Waiver Services: The needs, outcomes, goals and actions to be addressed by each of these DMRS or Medicaid HCBS Waiver services are reflected in the Action Plan of this ISP. The providers approved below for these authorized services are responsible for carrying out this ISP and meeting the health and personal safety needs of this person.

A	B	C	D	E	F	G	H	(DMRS USE ONLY)		
Service Name & *Type of Request	**Tier**	**Service Code & Fund Source**	**Provider Name & Provider Code**	**Site Name & Site Code**	**Start Date & End Date**	**Unit Rate & Unit Type**	**# of Units & Cost**	Approve	Deny	**Deny & Partial Approve
1								[ ]	[ ]	[ ]
							0.00			
2								[ ]	[ ]	[ ]
							0.00			
3								[ ]	[ ]	[ ]
							0.00			
4								[ ]	[ ]	[ ]
							0.00			
5								[ ]	[ ]	[ ]
							0.00			
6								[ ]	[ ]	[ ]
							0.00			
7								[ ]	[ ]	[ ]
							0.00			
8								[ ]	[ ]	[ ]
							0.00			

DMRS Review and Authorization of Services: Total Cost: $ 0.00

(Authorizing Signature) (Title) (Date)

* **TYPE OF REQUEST**: **1.** Continue Service **2.** Add New Service **3.** Assessment **4.** Delete Service **5.** Increase Service **6.** Decrease Service **7.** Add/Change Provider

* * **PARTIAL APPROVAL BY DMRS**: For partial approval of a request, DMRS must complete the following page to indicate details of the partial approval.

(Edition Type)

[ ] Amended Section C2

INDIVIDUAL SUPPORT PLAN

(Person's Full Name)

ISP Effective Date:

Date ISP Amended:

C. SERVICES AND SUPPORTS

PARTIAL APPROVAL OF A SERVICE DENIED BY DMRS

(This section is to be completed only by DMRS for partial approval of a DMRS or Medicaid HCBS Waiver Service.)

A	B	C	D	E	F	G	H	(DMRS USE ONLY)
Service Name & Type of Request	**Tier**	**Service Code & Fund Source**	**Provider Name & Provider Code**	**Site Name & Site Code**	**Start Date & End Date**	**Unit Rate & Unit Type**	**# of Units & Cost**	Partial Approval
1.							0.00	[ ]
2.							0.00	[ ]
3.							0.00	[ ]
4.							0.00	[ ]
					Total Cost:		$ 0.00	

(Edition Type)

[ ] Amended Section D

INDIVIDUAL SUPPORT PLAN

(Person's Full Name)

ISP Effective Date:

Date ISP Amended:

D. BEHAVIOR SUPPORT PLAN

1. Attach a Copy of the Behavior Support Plan where applicable or, if being amended, attach the amended Behavior Support Plan.

(Edition Type)

INDIVIDUAL SUPPORT PLAN

(Person's Full Name)

ISP Effective Date:

Date ISP Amended:

[ ] Amended Section E

E. PLANNING MEETING SIGNATURE SHEET

Complete Section G only if the person is enrolled in the Tennessee Self-Determination Waiver Program.

Choice of Self-Direction Of Services: Please indicate your choice**.**

[ ] I want to self direct the following services through the Tennessee Self-Determination Waiver Program:

- [ ] Personal Assistance
- [ ] Day Services (excludes facility-based services)
- [ ] Respite Services (excludes out-of-home respite)
- [ ] Individual Transportation Services
- [ ] Environmental Accessibility Modifications
- [ ] Vehicle Accessibility Modifications

[ ] I do **not** want to self-direct my services through the Tennessee Self-Determination Waiver Program at this time.

_____ _____

Signature of Person Date

_____ _____

Signature of Conservator/Legal Representative Date

(Edition Type)

[ ] Amended Section F

INDIVIDUAL SUPPORT PLAN

(Person's Full Name)

ISP Effective Date:

Date ISP Amended:

F. PLANNING MEETING SIGNATURE SHEET

Signature of Person or the Conservator/Legal Representative: By signing here, the person or the conservator/legal representative acknowledges participation in the planning meeting and acceptance of the Action Plan drafted during the meeting. A copy of the final ISP will be provided to the person or the conservator/legal representative for approval following the meeting and will be implemented by the effective date unless the ISP is contested or appealed.

X_____ _____ _____

Signature of Person or Conservator/Legal Representative | **Title or Relationship** | **Date**

Date of Planning Meeting: _____

Signatures of Planning Meeting Participants: Please print your name and then sign beside it in the spaces indicated below to acknowledge attendance at the planning meeting and participation in the drafting of the Action Plan. A final copy of the approved ISP will be provided to participants prior to the effective date.

Name / Affiliation (Please print.)	**Signature**	**Name/ Affiliation** (Please print.)	**Signature**